Clinical Oncology
The Royal College of Radiologists

FINAL EXAMINATION FOR THE FELLOWSHIP IN CLINICAL ONCOLOGY – PART B APRIL 2023

The Examining Board has prepared the following report on the April 2023 sitting of the Final Examination for the Fellowship in Clinical Oncology. It is the intention of the Fellowship Examination Board that the information contained in this report should benefit candidates at future sittings of the examinations and help those who train them. This information should be made available as widely as possible.

EXAMINERS' REPORT

Categories	Number of passing candidates from total number taking the examination	%
Overall	43 / 93	46%
UK	22 / 28	79%
UK 1st attempters	21 / 23	91%
NHS Contributors	6 / 14	43%
Global (all)	15 / 51	29%

Clinical Examination:

Total Score in clinicals (range)	Number of candidates (out of 93)
10 – 15	0
16 - 20	6
21 - 25	29
26 - 30	45
31 - 35	12
36 – 40	1

Oral Examination:

Total Score in orals (range)	Number of candidates (out of 93)
0 - 25	1
26 – 30	2
31 – 35	13
36 – 40	20
41 - 45	31
46 – 50	16
51 – 55	8
56 – 60	2
61 – 64	0

The examination was delivered online via the MS Teams platform, with the candidates at one of our remote venues, and the UK examiners based at the RCR premises in London. During this exam 93 candidates were examined across 6 venues in both the UK and India.

We would like to thank the local examiners in India for their help in examining and marking the candidates. It

was a great pleasure to work with them again.

During the exam the members of the Board were grateful for all the administrative and IT support provided by the College staff. We would also want to thank the invigilators in the various regional facilities who made it possible.

From an IT perspective things ran very smoothly with only minor incidents.

However, the most significant incident during the exam was an administrative error at the Crewe examination centre which led to candidates arriving on Saturday morning for the Clinical part of the exam without local invigilators being present. This was clearly a very stressful experience for them and everyone on the Board felt great sympathy for how they must have felt. Thankfully, it was possible to reschedule their exam to the afternoon but we fully appreciate how difficult it must have been. Clearly, a detailed review of how this could have happened will take place and plans will be put in place to try and prevent this ever happening again.

Feedback :

As a Board we are keen to provide feedback that will prove helpful to future candidates and their trainers.

The following are some general themes that were noted by members of the Board:

In modern radiotherapy it is standard to be given plan assessment forms plans prior to prescription and clinical oncologists are required to decide how to proceed. Candidates are encouraged to be part of this process for plans they have been involved in and learn how to make decisions about when to re-plan, how some problems can be improved by changing set up (eg breath hold techniques) or when to proceed whilst accepting risks of late toxicity.

The exam seeks to test clinical decision making as well as treatment delivery. In some situations, best supportive care can be the most appropriate option for the patient presented. This was the case in one of our emergency scenarios. As ever, candidates are advised to imagine the patient being described in their own clinic or ward and are encouraged to describe what they would do in everyday practice.

Although we no longer have a bedside clinical exam, the Board still feels candidates should be able to identify clinical signs. For this reason we use clinical photos / videos. Surprisingly, during this exam, many candidates failed to identify a clear, partial facial nerve palsy in a patient with evidence of prior surgery in the temporal region and a large recurrent mass in the parotid.

In current practice, radical treatments for localised lymphoma are usually performed to planned volumes using accepted guidelines. The Board were surprised how many candidates chose to offer radical treatment to an isolated deposit of low grade lymphoma in the spine using a single posterior field. Some even offered a single fraction of palliative radiotherapy to “one vertebra above and below” which was felt inappropriate in this situation.

Similarly, many candidates did not appreciate that a low palliative dose of 4Gy/2# would be suitable for a bothersome conjunctival lymphoma in an elderly man with dementia. This again emphasises the need to tailor treatment to the specific patient being described in a case.

Despite advice after previous sittings of the exam it was also noticed that many candidates still seemed very unfamiliar and unsure about how to interpret cone beam images. This is a core skill in modern radiotherapy and, although radiographers often take a lead on it, clinical oncologists are often required to make on-treatment decisions related to image-guidance. Trainees are encouraged to gain experience of this during their attachments.

Several candidates volunteered electron treatments for large tumours extending round curved surfaces. In doing so they seemed to fail to appreciate the uncertainties about dosimetry that arise from that. In such situations photon-based treatments are usually preferable.

It is recommended that candidates avoid vague terms such as “a metastatic work up” or “a metabolic screen” during the exam since they are so poorly defined. The examiners want to know specifics eg “I would request a CT chest / abdomen / pelvis” or “I would be concerned about immunotherapy toxicity and request TFTs, cortisol as well as routine u+es/ LFTs”

Managing the toxicity of common treatments (eg the cardiac toxicity of drugs used in breast cancer) is considered an important skill for trainees at this level. Candidates are strongly advised to gain experience of this in clinic.

Only a minority of candidates appreciated there would be difficulty stenting the mediastinal mass in one of the emergency cases (even when prompted to consider why this might be difficult). Furthermore, with this extent of small cell lung cancer (including spinal mets) some were still proposing concurrent chemoRT or palliative radiotherapy to this massive field in a chemosensitive tumour. In previous reports we have pointed out that in very chemosensitive metastatic disease the first choice treatment is chemotherapy if the patient is fit enough.

When listing the side effects of treatment it is important to calibrate the risks if possible. Some candidates were warning of blindness / optic neuropathy when giving 24Gy/12# to the orbit. This is clearly so unlikely that to suggest it as a possibility raises concern for a candidate’s knowledge. It was also noted that many candidates were unaware of the side effects of procarbazine.

Summary:

The Spring 2023 sitting of the FRCR 2B exam was delivered successfully. The Board would like to offer their thanks to everyone involved in making it happen and congratulate those candidates who have successfully passed.